Summary of Benefits

Medicare Plus Blue Group℠

January 1, 2008 – December 31, 2008

Medicare PLUS Blue Group℠

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Medicare Plus Blue Group is a private fee-for-service plan with a Medicare contract. Medicare Plus Blue Group is issued by Blue Cross Blue Shield of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

State of Michigan

CB 5931 OCT 07

H2319_O8SOMSOBrev 110807

Glossary of Terms

Approved amount

The lower of the provider's billed charge or the Medicare maximum payment amount, whichever is lower.

Coinsurance

The amount you may be required to pay for services after you pay any plan deductibles. This is a percentage (%). You have to pay this amount after you pay the deductible.

Coordination of benefits

Applies when a member is covered by more than one health plan, to maximize coverage without duplicating payments. One plan is designated as primary for liability. Additional plans may cover remaining balances on the claim.

Copayment

The amount you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay. Example: $10

Deductible

The amount you must pay out-of-pocket for health care services, before your insurance begins to pay. A type of cost sharing in which the individual pays a specified amount for covered services before the health plan pays benefits.

Dependent

A person who is eligible for health care coverage on another individual's contract (a spouse and/or child eligible for coverage).

Medically necessary

Services or supplies that are medically needed for the diagnosis or treatment of your medical condition. Must meet the standards of good medical practice and consistent with Medicare guidelines.

SECTION 1

Introduction to the Summary of Benefits for State of Michigan Medicare Eligible Retirees

Medicare Plus Blue Group

January 1, 2008 – December 31, 2008

Hospital and medical coverage for Medicare members

On January 1, 2008, your State Health Plan PPO coverage will be continued under the new State of Michigan Retiree Medicare Advantage plan called **Medicare Plus Blue Group**. This plan combines the State Health Plan PPO with Medicare Parts A and B. You will continue to pay your Medicare Part B premium. Blue Cross Blue Shield of Michigan (BCBSM) will administer the plan. The **Medicare Plus Blue Group** plan does not include prescription drug, dental or vision benefits. You will continue to access these benefits using your Express Scripts, Delta Dental or your BCBSM Vision ID card depending on the benefit. If you are enrolled in the **Medicare Plus Blue Group** plan, your Mental Health and Substance Abuse benefits through this plan will be administered by BCBSM.

Eligibility

You will be covered by **Medicare Plus Blue Group** if you are enrolled in Medicare Part A and Part B. If you become eligible for Medicare after January 1, 2008, it is important that you are enrolled in Medicare Part A and Part B coverage in order to continue State Health Plan coverage under the **Medicare Plus Blue Group** plan. Once you have Medicare Part B coverage, you will be moved to the **Medicare Plus Blue Group** plan and will receive detailed plan information and a new ID card.

Retirees, spouses or dependents who are not Medicare eligible will remain in the State Health Plan PPO. Current retirees who are not enrolled in Medicare Part B will continue to be covered under the State Health Plan PPO and will be responsible for the Medicare portion of Part B services. If you are not eligible for Medicare Parts A and B, (e.g., State Police not eligible to participate in Medicare) you will also continue to be covered under the State Health Plan PPO.

Medicare requires that an individual only be covered under one Medicare Advantage plan. If you are also covered under a Medicare Advantage plan under your spouse's insurance, you will need to choose which plan you wish to remain enrolled in. If you have other health coverage that pays claims after Medicare Part A and B, but before the State Health Plan PPO, you will not be enrolled in the **Medicare Plus Blue Group** plan. You will remain in the State Health Plan PPO.

Opting Out

You have the option not to take this Medicare Plus Blue Group. As a Medicare Beneficiary, you can choose from different Medicare options. For more information, call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048. You can call this number 24 hours a day, 7 days a week. Please be aware that if you decline coverage, everyone on your health care contract (all of your Medicare and non-Medicare-eligible dependents) will also be removed, and WILL NOT have coverage through the State of Michigan's State Health Plan. You and your Medicare-eligible dependents will only be covered by original Medicare. If you decide to drop coverage you will need to complete the enclosed Opt-Out Form and return it to Blue Cross Blue Shield of Michigan at the address listed on the form NO LATER THAN December 10, 2007.

Out-of-state coverage

The **Medicare Plus Blue Group** coverage for retirees living out-of-state is the same as retirees living in Michigan. Retirees living out-of-state should seek services from providers who are eligible to participate with Medicare and are willing to accept the **Medicare Plus Blue Group** terms and conditions of payment. When you go to a doctor or hospital be sure to show them your **Medicare Plus Blue Group** ID card.

SECTION 2 — Summary of Benefits

Medicare PLUS Blue Group℠

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

COMPARING MEDICARE PLUS BLUE GROUP to the Current (2007) STATE HEALTH PLAN AND ORIGINAL MEDICARE

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Preventive Services				
1	Routine Physical/Health Maintenance Exam	Coverage remains the same	Covered – 100% one every 12-months	Not Covered
2	Pelvic/GYN Exam Screening	Coverage remains the same	Covered – 100% one every 12-months	Covered – 80% one every 24-months
3	PAP Smear Screening (lab services only)	Coverage remains the same	Covered – 100% one every 12-months	Covered – 100% one every 2 years
4	Immunizations – Pneumonia & Flu Vaccines	Coverage remains the same	Covered – 100%	Covered – 100%
5	Immunizations – Hepatitis B Vaccine	Coverage remains the same	Covered – 100%	Covered – 80% after deductible
6	Other Immunizations	Coverage remains the same	Covered – 100%	Not Covered
7	Fecal Occult Blood Screening	Coverage remains the same	Covered – 100% for age 50+	Covered – 100% for age 50+
8	Flexible Sigmoidoscopy Screening	Coverage remains the same	Covered – 100% for age 50+	Covered – 80% for age 50+
9	Prostate Specific Antigen Screening (PSA)	Coverage remains the same	Covered – 100% for age 50+	Covered – 100% for age 50+

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Other Preventive Services				
10	Mammography (annual screening)	Coverage remains the same for age 40+	Covered – 100% no age restrictions	Covered – 80% for age 40+
11	Colonoscopy Screening	Coverage remains the same	Covered – 100%	Covered – 80%
Physician Office Services				
12	Office Visits, Consultations and Urgent Care Visits	Same coverage with a flat $10 member copay	Covered – up to $10 member copay	Covered – 80% after deductible
13	Outpatient and Home Visits (outpatient hospital visit or physician to member's home)	Same coverage with a flat $10 member copay	Covered – 100% after deductible	Covered – 80% after deductible
Emergency Medical Care				
14	Hospital Emergency Room – Medical Emergency or Accidental Injury	Coverage remains the same	Covered – 100%	Covered – 80% after deductible
15	Ambulance Services	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic Services				
16	Laboratory & Pathology Tests (excludes clinical lab services)	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
17	Clinical Laboratory Services	Covered – 100%	Covered – 100% after deductible	Covered – 100%
18	Diagnostic Tests and X-rays (excludes chiropractic X-rays)	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
19	Radiation Therapy	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Hospital Care				
20	Inpatient Hospital Care (excludes Mental Health/ Substance Abuse)	Coverage remains the same	Covered – 100% after deductible; unlimited days	2007 Deductibles: $992 inpatient $248 a day for days 61-90 $496 a day for days 91-150 2008 Deductibles: $1024 inpatient $256 a day for days 61-90 $512 a day for days 91-150 (Medicare guidelines apply)
21	Inpatient Physician Care (excludes Mental Health/ Substance Abuse)	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
22	Blood – Inpatient and Outpatient (first three pints)	Coverage remains the same	Covered – 100% after deductible	Not Covered
23	Inpatient Consultation	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
24	Chemotherapy	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
25	Chemotherapy, Oral Cancer & Oral Anti-Nausea Drugs	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
Alternatives to Hospital Care				
26	Skilled Nursing Facility (SNF) (in a Medicare-certified SNF)	Covered – 100% after deductible 120 days per admission	Covered – 100% after deductible 120 days per admission Renews after 90 days	2007 Medicare: Following a 3+ day covered hospital stay: Days 1-20: $0 for each day; Days 21-100: $124 for each day; Limit of 100 days for each benefit period 2008 Medicare: Following a 3+ day covered hospital stay: Days 1-20: $0 for each day; Days 21-100: $128 for each day; limit of 100 days for each benefit period

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Alternatives to Hospital Care *continued*				
27	Hospice Care	Coverage remains the same	Covered – 100% (limited to the life-time dollar maximum adjusted annually)	Covered – Medicare-approved hospice program. Member is responsible for a 5% copay of the Medicare-approved amount for inpatient respite care
28	Home Health (includes intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)	Coverage remains the same	Covered – 100% after deductible	Covered – 100%
Surgical Services				
29	Surgery and Related Surgical Services	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
Human Organ Transplants				
30	Liver, Heart, Lung, Pancreas & Specified Human Organ Transplants (designated facilities only)	Coverage remains the same	Covered – 100% up to $1 million lifetime max per transplant type	Covered – 100%
31	Transportation, Lodging & Meals	Coverage remains the same	Covered – 100%	Not covered
Organ and Tissue Transplants				
32	Bone Marrow	Covered – 100%	Covered – 100% after deductible (designated facilities only)	Covered – 100% (Not covered for ovarian and breast cancer)
33	Cornea and Skin	Covered – 100%	Covered – 100% after deductible	Covered – 100%
34	Kidney Transplant	Covered – 100%	Covered – 100% after deductible	Covered – 100%

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Other Services				
35	Allergy Testing and Injections	Coverage remains the same	Covered – 100% after deductible	Covered – 80% after deductible
36	Eye Exam Diabetic Retinopathy Glaucoma Screening Macular Degeneration	Same coverage with a flat $10 member copay	Covered – up to $10 member copay	Covered – 80% after deductible
37	Glasses After Cataract Surgery	Coverage remains the same	Covered – 100% after deductible	Covered – 100% after deductible
38	Medical Hearing Exam	Same coverage with a flat $10 member copay	Covered – up to $10 member copay	Covered – 80% after deductible
39	Durable Medical Equipment Prosthetic and Orthotic App. Medical Supplies	Covered – 100%	Covered – 100% for Michigan SUPPORT program network. Covered – 80% if out-of-network. Outside Michigan, covered 90%.	Covered – 80% after deductible
40	Private Duty Nursing	Coverage remains the same	Covered – 90% after deductible	Not Covered
41	Renal Dialysis	Covered – 100% after deductible	Covered – 100% after deductible	20% coinsurance of Medicare-approved dialysis

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Outpatient Physical, Occupational & Speech Therapy				
42	Outpatient Occupational, Physical & Speech Therapy – Facility and Clinic Services	Covered – 100% after deductible	Covered – 100% after deductible; Annual 90-visit limitation combined	Covered – 80% after deductible
43	Outpatient Occupational, Physical & Speech Therapy – Physician's Office	Covered – 100% after deductible; Medicare cap applies	Covered – 100% after deductible; Annual 90-visit limitation (combined); Medicare cap applies	Covered – 80% after deductible (Included in $1780 cap)
Other Plan Benefits Covered by State of Michigan				
44	Acupuncture	Coverage remains the same	Covered – 90% after deductible; Up to 20 visits per calendar year	Not Covered
45	Chiropractic Spinal Manipulation	90% of Medicare-approved amount after deductible	Covered – 90% after deductible (24 visits per calendar year)	Covered – 80% after deductible
46	Chiropractic X-rays	Coverage remains the same	Covered – 100% after deductible	Not Covered
47	Chiropractic Office Visits	Coverage remains the same	Covered – $10 copay	Not Covered
48	Hearing Aids	Coverage remains the same	Covered – 100% payable every 36 months unless significant hearing loss occurs	Not Covered
49	Routine Hearing Exam	Coverage remains the same	Covered – $10 copay	Not Covered
50	Weight Loss Benefit	Coverage remains the same	Lifetime maximum of $300	Not Covered

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Mental Health and Substance Abuse Treatment				
51	Inpatient Mental Health (including Substance Abuse)	Covered – 100%; unlimited days	Inpatient mental health covered 365 days per year, with no deductible. Inpatient substance abuse limited to two 28 day stays per year with at least 60 days between episodes.	Same deductible and copayments as inpatient hospital care, except Medicare beneficiaries receive 190 days in a psychiatric hospital per lifetime. 2007 Medicare guidelines: Days 1 – 60: initial deductible of $992 Days 61 – 90: $248 each day Days 91 – 150: $496 each lifetime reserve day 2008 Medicare guidelines: Days 1-60: initial deductible of $1024 Days 61-90: $256 Days 91-150: $512 each lifetime reserve day.
52	Outpatient Mental Health	Coverage remains the same	Outpatient mental health unlimited benefit with 10% copay	Medicare covers mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department. 50% of Medicare-approved amount. There may be a separate 20% of Medicare-approved amount for the facility service.
53	Outpatient Substance Abuse	Member has a 10% copay for outpatient substance abuse services	Member has a 10% copay for outpatient substance abuse services with a $3500 annual maximum	Outpatient treatment centers covered, if they have agreed to participate in the Medicare program. 50% of Medicare-approved amount. May be a separate 20% of Medicare-approved amount for the facility service.

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

		2008 State Health Plan Medicare Advantage*	2007 Current Benefits State Health Plan PPO and Original Medicare	
			2007 Current State Health Plan PPO Pays after Original Medicare	2007 Original Medicare Pays Before SHP PPO
Deductible, Copays and Out-of-Pocket Dollar Maximum				
54	Out of Pocket Maximum	Annual coinsurance maximum: $1000 per individual member Family maximums not allowed under Medicare Advantage rules	Annual coinsurance maximums: $1000 per person $2000 per family	N/A
55	Medical Deductible	$200 per individual member Family deductibles not allowed under Medicare Advantage rules	$200 per member $400 per family	2007 Part A inpatient deductible per benefit period or spell of illness – $992 Part B Annual deductible – $131 2008 Part A inpatient deductible per benefit period or spell of illness – $1024 Part B Annual deductible – $135
56	Coinsurance	10% of Medicare-approved amount for some professional services.	10% of Medicare coinsurance amount for some professional services	20% Medicare's approved amount for most professional services
57	Copays	Flat $10 for office visits, clinic visits, outpatient visits/home visits, office consultations, urgent care, osteopathic manipulations and medical hearing exams.	Up to $10 copay for office visits, clinic visits, office consultations, urgent care, osteopathic manipulations and medical hearing exams	N/A

*Based on 2007 benefits. Any benefit changes will continue to be communicated through official Retiree Benefits Bulletins issued by the Civil Service Commission.

SECTION 3

Your Medicare Plus Blue Group ID card

Your **Medicare Plus Blue Group** identification card identifies your hospital and medical coverage. Each member enrolled in **Medicare Plus Blue Group** receives a card in his or her own name. Use this card each time you visit your provider instead of your red, white and blue original Medicare card. Be sure to retain your original Medicare card even though you will not be using it to access services under the new **Medicare Plus Blue Group** plan. Your covered spouse or dependent who is not yet Medicare eligible will continue to use their BCBSM State Health Plan PPO insurance card.

Using Medicare Plus Blue Group providers

The **Medicare Plus Blue Group** is a private fee-for-service Medicare Advantage plan, which allows you to see any doctor who is eligible to participate with Medicare and is willing to accept the **Medicare Plus Blue Group** terms and conditions of payment. Referrals are not needed to see a specialist, and there are not any network restrictions.

If you are seeking medical treatment, simply present your **Medicare Plus Blue Group** ID card. If the provider agrees to accept the card, then you are only responsible for your deductible or any copay or coinsurance depending upon the service you receive. You should not be billed for the balance between the approved amount and what the provider charged.

If you use a provider that does not accept BCBSM's terms and conditions for payment, you will be responsible for payment to the provider. If your provider is not familiar with the terms and conditions of the **Medicare Plus Blue Group** plan, he or she may call our Provider Services Representatives at 1-866-309-1719 or visit **www.bcbsm.com/ma** for more information.

As always, in a medical emergency, you are covered regardless of where you receive treatment. This includes when traveling within the United States or abroad.

YOUR OUT-OF-POCKET COSTS

As a member of **Medicare Plus Blue Group**, you can use any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms and conditions of payment of the BCBSM **Medicare Plus Blue Group** plan. BCBSM has the right to determine if the service or treatment ordered by your health care provider is covered under the **Medicare Plus Blue Group** plan. This decision is based on your plan design.

You are responsible for your coinsurance, copayments and annual deductible. Your coinsurance and copayments vary according to the services you receive as we have outlined in this benefit summary. The annual deductible in 2008 is $200 per member per year. This is applied from January 1, 2008 through December 31, 2008. Under the **Medicare Plus Blue Group** plan, there is not a family deductible.

The following are some examples to show you how the deductible under **Medicare Plus Blue Group** would apply:

Scenario #1: *Both retiree and spouse are enrolled in the **Medicare Plus Blue Group**.* The retiree's deductible is $200 and the spouse's deductible is $200 each year.

Scenario #2: *The retiree is enrolled in the **Medicare Plus Blue Group**. The spouse has the State Health Plan PPO.* The retiree's deductible is $200 and the spouse's deductible is $200 each year.

Scenario #3: *Both the retiree and the spouse are enrolled in **Medicare Plus Blue Group**. A dependent child is covered under the State Health Plan PPO.* The retiree's deductible is $200 and the spouse's deductible is $200. The deductible for the one dependent is $200. That results in a total of $600 for all deductibles each year.

Scenario #4: *Both the retiree and the spouse are enrolled in **Medicare Plus Blue Group**. There are three additional dependents that are covered under the State Health Plan PPO.* The retiree's deductible is $200 and the spouse's deductible is $200 each year for **Medicare Plus Blue Group**. Their three dependents are covered as "family" under the State Health Plan PPO, which has a $400 deductible each year. This results in a total of $800 for all deductibles each year.

GRIEVANCES

As a member of **Medicare Plus Blue Group** you have the right to file a grievance. If you have a complaint, we encourage you to first call Customer Service at 1-888-322-5557, TTY/TDD 1-800-579-0235, 8:30 a.m. to 5:00 p.m. EST, Monday through Friday. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. If you wish to file a grievance, contact our Appeal and Grievance department at 1-800-545-7100, TTY/TDD 1-877-924-2583 from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday, or in writing to: **Medicare Plus Blue Group**, Appeal and Grievance Dept. Mail code: X509, 600 E. Lafayette, Detroit, Michigan 48226-2998.

APPEALS

As a member of **Medicare Plus Blue Group** you have the right to file an appeal if you are not satisfied with the outcome of the plan's determination of health care services. An appeal is a request in writing for a reconsideration of health care service or an amount the member pays for service. If the situation requires an urgent response, we can expedite your request. Please call us at 1-800-545-7100, TTY/TDD 1-877-924-2583 from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday, or write to us at **Medicare Plus Blue Group**, Appeal and Grievance Dept. Mail code: X509, 600 E. Lafayette, Detroit, Michigan 48226-2998.

TERMS & AGREEMENTS

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions of payment prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our Web site at: **www.bcbsm.com/ma**

For more information about PFFS plans see Beneficiary Qs&As at CMS's Web site: **http://www.cms.hhs.gov/PrivateFeeforServicePlans/downloads/benqa.pdf**.

Please read this Important Information regarding Medicare Plus Blue Group

As a State of Michigan retiree I understand that:

- BCBSM **Medicare Plus Blue Group** plan is a Medicare Advantage plan which requires that I keep my Parts A and B.
- I can only be in one Medicare Advantage plan at a time.
- I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
- Once I am a member of **Medicare Plus Blue Group**, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read an Evidence of Coverage document from BCBSM **Medicare Plus Blue Group** that will provide detailed guidelines I must follow in order to receive coverage under Medicare Advantage plans.
- By joining the BCBSM **Medicare Plus Blue Group** plan, I acknowledge that this Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

IF YOU ARE OPTING OUT OF COVERAGE, PLEASE READ THIS INFORMATION ABOUT MEDIGAP RIGHTS:

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. Your State may have laws that provide more Medigap protections. If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program Medicare/Medicaid Assistance Program of Michigan (MMAP) at 1-800-803-7174 to get more information about Medigap policies in your State.

Call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week for more information about trial periods.

WHAT PEOPLE ON MEDICARE NEED TO KNOW ABOUT PRIVATE FEE-FOR-SERVICE PLANS

Medicare Plus Blue Group is a Medicare Advantage Private Fee-for-Service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO, or Medicare supplement plan.

With **Medicare Plus Blue Group**, you are able to choose your health care provider. However, just like with the State Health Plan PPO and Original Medicare, most but not all providers may accept this plan. As with your current health care plan, if you choose this plan, it is important that your providers know that you have **Medicare Plus Blue Group** coverage before providing services to you. You must show your **Medicare Plus Blue Group** ID card every time you visit a health care provider because providers have the right to decide if they will accept **Medicare Plus Blue Group** each time they see you. By agreeing to accept your **Medicare Plus Blue Group** ID card, your provider is agreeing to accept **Medicare Plus Blue Group**'s terms and conditions of payment for treating you. They will bill **Medicare Plus Blue Group** for services rendered to you.

If a provider does not agree to BCBSM's **Medicare Plus Blue Group**'s terms and conditions of payment, you will need to find another provider that will. You may contact us at Customer Service at 1-888-322-5557 for assistance in locating another provider in your area.

If a provider will not accept **Medicare Plus Blue Group**'s terms and conditions of payment, they should not treat you unless it is an emergency. If they choose to provide non-emergency services to you, they may not bill you. They must bill **Medicare Plus Blue Group** for your covered health care services. All you will have to pay is your copay or coinsurance at the time of service.

For more information about PFFS plans, see Beneficiary Q&As at CMS's Web site at **http://www.cms.hhs.gov/Privatefeeforserviceplans/downloads/benqa.pdf**.

If you have questions about BCBSM's **Medicare Plus Blue Group**, please call our Customer Service at 1-888-322-5557, TTY/TDD 1-800-579-0235.

This publication is not a contract, but a brief outline of Blue Cross Blue Shield of Michigan's Medicare Advantage health plan for State of Michigan retirees for 2008. The information provided here does not include all covered and non-covered services or conditions of coverage. Coverage, including deductibles and copays, are subject to change. You always have the right to ask BCBSM to review claims.

BCBSM's contract with the Center for Medicare and Medicaid Services (CMS) is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed. We may, at a future date, decide to discontinue integrating health coverage with Medicare Part A or Part B. If this occurs, we will notify you in writing at least 90 days before participation ends. You will not lose Medicare coverage and State Health Plan retiree coverage will continue.

Notes

Notes

For more information about this plan:

Visit us at **www.bcbsm.com** or, call Customer Service,
Hours: 8:30 a.m. to 5:00 p.m., EST,
Monday through Friday 1-888-322-5557,
TTY/TDD 1-800-579-0235

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227), TTY/TDD 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit **www.medicare.gov** on the Web.

If you have special needs, this document may be available in other formats.

Medicare PLUS Blue Group℠

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

072362MCPB_Nov16